Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

REQUEST FOR SUBMITTER ID NUMBER AND INFORMATION SHEET

(Note: To submit claims electronically you will need a Submitter ID number assigned to your regular billing Provider Number)

PROVIDER'S NAME		MEDICAID PROVIDER NUMBER	
PROVIDER'S ADDRESS	CITY	STATE	ZI
PROVIDER'S TELEPHONE NUMBER	PROVIDER'S CONTACT NAME(S)		

Billing Intermediary

Complete this section if you have chosen a third party intermediary to submit Medicaid claims for you. (Note: If this option is selected, the "Power of Attorney" form must also be completed and notarized.)

INTERMEDIARY'S NAME		INTERMEDIARY'S SUBMITTER ID NUMBER	
INTERMEDIARY'S ADDRESS	CITY	STATE	ZI
INTERMEDIARY'S TELEPHONE NUMBER	INTERMEDIARY'S CONTACT NAME(S)		

Provider to Submit Own Claims

Complete this section if you wish to submit your own claims electronically. (Note: For this option, you will need a submitter ID number of your own in addition to your own regular billing provider number.)

☐ Please assign me a submitter ID number.

We will be submitting claims via the following method(s):

- ☐ Crosstalk (Bulletin board telecommunication software)
- ☐ Direct Entry (MMIS emulation terminal at your location)
- ☐ ECS (Electronic Claims Submission via the Internet)
- ☐ Floppy Diskette (Mailed)
- ☐ Magnetic Tape (Mailed)
- ☐ Mainframe to Mainframe (Telecommunication transaction directly to MMIS)

Send to: Provider Enrollment
Electronic Billing Agreement Processing Dept.
PO Box 45562
Olympia WA 98504-5562
1-866-545-0544